STATE OF INDIANA	)	**BEFORE THE INDIANA**
	) **SS:**	
COUNTY OF MARION	)	**COMMISSIONER OF INSURANCE**
	)	
	)	**WARRANT NUMBER: IDOI- MC07-0309-040**
	)	
	)	
IN THE MATTER OF:	)	
	)	
The Medical Assurance Company, Inc.	)	
100 Brookwood Place	)	
Birmingham, AL 35209	)	
	)	
Market Conduct Examination	)	

FILED

DEC 16 2009

STATE OF INDIANA
DEPT. OF INSURANCE

AGREED FINAL ORDER

On October 29, 2009 the Consumer Services Division of the Indiana Department of Insurance ("Department") received the verified report of the examiner in this market conduct examination (the "Report"). Pursuant to Ind. Code § 27-1-3.1-10(b), the company examined was given a reasonable opportunity to make a written submission or rebuttal with respect to any matters contained in the Report. The Commissioner, having reviewed the materials submitted and pursuant to Ind. Code § 27-1-3.1-11, now hereby issues the following order:

WHEREAS, the Commissioner of Insurance of the State of Indiana ("Commissioner") is a duly authorized and appointed official of the State of Indiana, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, The Medical Assurance Company, Inc., NAIC # 33391 ("Medical Assurance") is authorized to conduct the business of insurance in the State of Indiana as a Property and Casualty insurer; and

WHEREAS, a market conduct examination of Medical Assurance was conducted by duly appointed independent examiners under contract with the Department pursuant to Indiana Code sections 27-1-3.1-8 and 27-1-3-1.9; and

WHEREAS, a copy of a draft report was provided to Medical Assurance on or about January 22, 2008; and

WHEREAS, Medical Assurance was provided an opportunity to review the draft Report and submit a rebuttal/response; and

WHEREAS, on October 29, 2009 the examiners filed a verified Report with the Department as a result of the market conduct examination pursuant to Indiana Code section 27-1-3.1-10(b), attached as Exhibit 'A'; and

WHEREAS, the verified report was subsequently provided to Medical Assurance; and

WHEREAS, a written response to the verified report was received from Medical Assurance on December 15, 2009, attached as Exhibit 'B'; and

WHEREAS, said Report identified several issues and violations of Indiana law and made four recommendations for corrective action to be undertaken by Medical Assurance; and

WHEREAS, Medical Assurance was provided sufficient notice and opportunity to respond to all four recommendations; and

WHEREAS, Medical Assurance has submitted a Corrective Action Plan to comply with the recommendations within the Report, (attached as Exhibit "C"). ;and

WHEREAS, Medical Assurance is aware of and understands its various rights in connection with the examination and Report, including the right to rebuttal, notice, and appeal under Indiana Code sections 27-1-3.1-10, 27-1-3.1-11, and 27-1-1-3.1-12; and

WHEREAS, Medical Assurance has agreed to immediately move to Dismiss with Prejudice its Verified Petition for Judicial Review previously filed in the Superior Court of Marion County.

IT IS THEREFORE ORDERED by the Commissioner of Insurance:

1. The Report of the examiner shall be and is hereby adopted and incorporated herein as filed.

2. The Department accepts and adopts all four recommendations as stated in the Report.

3. Medical Assurance shall adopt and implement procedures to ensure a current claims manual or current written claims procedures are maintained. Medical Assurance shall provide the Department with a compliance plan demonstrating how it will institute procedures to ensure a claims manual or written claims procedure will be published and maintained in a current form.

4. Medical Assurance shall adopt and implement procedures to ensure that complete claims files and other related claims information is maintained for the purposes of regulatory review. Medical Assurance shall provide the Department with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

5. Medical Assurance shall adopt and implement procedures to ensure that loss reserves are established and reevaluated, with procedures to ensure prompt and timely notification to the Department in accordance with Indiana law when the loss reserve on a medical malpractice claim reflects potential liability for the Indiana Patient's Compensation Fund

6. Medical Assurance shall adopt and implement procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. Medical Assurance shall provide the

Department with a compliance plan demonstrating how the company will verify that it properly reports reserves reaching at least $125,000.

7. Medical Assurance shall provide the Consumer Services Division with a written report verifying compliance with all terms and dates provided in the compliance plan and all requirements of this Agreed Final Order.

ALL OF WHICH IS ORDERED THIS 16th DAY OF December, 2009.

Carol Cutter, Commissioner
Indiana Department of Insurance

Distribution to:

Debra M. Webb, Attorney
Indiana Department of Insurance
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MARKET CONDUCT EXAMINATION REPORT

OF

THE MEDICAL ASSURANCE COMPANY, INC

AS OF

DECEMBER 31, 2006

NAIC COMPANY CODE 33391

EXHIBIT

A

MARKET CONDUCT
EXAMINATION REPORT
OF
THE MEDICAL ASSURANCE COMPANY, INC.

TABLE OF CONTENTS

October 29, 2009

Honorable Carol Cutter
Insurance Commissioner
State of Indiana
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Dear Commissioner Cutter:

In compliance with instructions contained in Examination Warrant Number IDOI-MC07-0309-040, and pursuant to the statutory provisions found in IC 27-1-1-1 and IC 27-1-3.1-9 of the Indiana insurance laws, a target market conduct examination has been performed to determine the medical malpractice claim settlement practices of:

The Medical Assurance Company, Inc.

The examination was performed at the Indiana office of ProAssurance Group located at 5975 Castle Creek Parkway North, Suite 300, Indianapolis, Indiana 46250.

This report covers the period from January 1, 2002 through December 31, 2006.

The report of examination thereon is respectfully submitted.

II. COMPANY PROFILE

The Medical Assurance Company, Inc. (herein after referred to as "the Company") was incorporated as Mutual Assurance Society of Alabama, a mutual insurance company, on October 1, 1976 and commenced business on April 15, 1977 under the laws of the State of Alabama. In January 1987, the Company amended its name to Mutual Assurance, Inc. On September 11, 1991, the Company converted from a mutual company to a stock company and in October 1999, the Company changed its name from Mutual Assurance, Inc. to the current name of The Medical Assurance Company, Inc.

In May 1995, the Company purchased Physicians Insurance Company of Indiana and then merged it into the Company with the Company being the surviving corporation. In June 2001, a new holding company, ProAssurance Corporation, was formed and this holding company indirectly owns 100% of the stock of the Company.

The Company was granted a Certificate of Authority to write business in Indiana on February 1, 1996. The Company is licensed to write business in forty-four (44) states and actively writes business in eighteen (18) of these states.

III. EXECUTIVE SUMMARY

The examination resulted in five (5) issues arising from the Company's lack of compliance with Indiana insurance laws. These five (5) issues are shown below under Risk Assessment and Standards 3 and 8.

Risk Assessment:

In the risk analysis phase, one (1) compliance issue is addressed in this report. This issue arose from Indiana insurance law requirements as well as the Indiana medical malpractice laws which fall under the jurisdiction of the Indiana Department of Insurance (IDOI). These laws deal with fair and equitable claims settlements practices and other claims handling practices. The issue in this phase of the examination is identified as follows:

The Company does not maintain a claims manual or written claims procedures

In addition to the above, the following items were also noted:

- The Company does not maintain written claims reserving procedures
- During the examination period, the Board of Directors was made up of five (5) senior officers of the Company. The Parent Company Board includes external independent directors.
- The Indianapolis ProAssurance office underwent two (2) internal audits during the examination period. Four (4) recommendations or comments were noted in the 2002 audit report. The auditors made no recommendations or comments in the 2006 internal audit report.
- The Company performed six (6) internal audits of defense counsel firms during the examination period. Seven (7) significant items were noted during these audits.
- No compliance issues were noted in the area of complaint handling.

Claim Practices:

In the area of claim practices, four (4) compliance issues are addressed in this report. These issues arose from Indiana insurance law requirements as well as the Indiana medical malpractice laws which fall under the jurisdiction of the IDOI. These laws deal with fair and equitable claims settlements practices and other claims handling practices. The issues in this phase of the examination are identified as follows:

- **Standard 3: Claim files are adequately documented.**

The Company could not produce one (1) closed without payment claim file requested for review.

- **Standard 8: Claim files are reserved in accordance with the Company's established procedures and the Company follows applicable laws and regulations as required under Indiana medical malpractice statutes.**

There were two (2) closed without payment claims and eight (8) paid claims where reserves reached or exceeded statutory reporting limits without proof of notification being sent to the IDOI as required by IC 34-18-9-3(a).

The Company routinely set loss reserves at $10,000 to $12,500 and did not usually increase them until close to the settlement date. The review of paid claims showed sixteen (16) claims where potential damages could reach or exceed the statutory reporting level, but these reserves were not increased until the claims were settled or a jury verdict was rendered.

IV. PURPOSE AND SCOPE OF EXAMINATION

This market conduct report was prepared by RSM McGladrey Inc. (RSM McGladrey), an independent contractor with the Indiana Department of Insurance (IDOI) for the purpose of auditing the Company's medical malpractice claims settlement practices in the State of Indiana. This procedure is in accordance with IC 27-1-3.1-9(d) of the Indiana insurance laws, which empowers the Commissioner to retain independent contractors. The findings in this report, including all work product developed in the production of this report, are the sole property of the IDOI.

The purpose of the examination was to determine the Company's compliance with Indiana insurance laws in general and, specifically, with Indiana's Unfair Claims Settlement Practices Act, IC 27-4-1-4.5. Examination information contained in this report should serve only these purposes.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners (NAIC) and the IDOI. In reviewing material for this report, the examiners relied primarily on records and materials maintained by the Company. The examination covered the five (5) year period from January 1, 2002 to December 31, 2006.

File sampling was based on a review of claim files systematically selected using Audit Command Language (ACL™) software and computer data files provided by the Company. Sample sizes were chosen based on procedures developed by the NAIC. After the review of files, any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding by a comment form, the Company had the opportunity to agree, disagree or explain the Company's noted action on the comment form.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance by the IDOI. Examination findings may result in administrative action by the IDOI.

RSM McGladrey personnel participated in this examination in their capacity as market conduct examiners. RSM McGladrey provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the IDOI.

V. EXAMINATION METHODOLOGY

The examination consisted of a review of the Company's medical malpractice claims settlement practices to determine its compliance with Indiana insurance laws. A limited risk analysis was also performed to evaluate the Company's operations and management in order to determine if any weakness appeared to exist in these areas.

Complaints

The examination included a review of Company complaints. The IDOI's complaint database log was compared to the Company's complaint log data to determine complete complaint activity. A total of four (4) claims complaints against the Company had been filed with the IDOI during the examination period. Each of these complaints was reviewed for proper complaint handling procedures and to determine if a pattern of complaints existed that would indicate a need for further claims handling review. No further review was determined to be necessary.

Claims

For the period under examination, (January 1, 2002 through December 31, 2006) samples were systematically selected to determine compliance.

Data List	Population	Sample Size	Percentage to Population
Paid Claims	369	50	13.55%
Claims Closed Without Payment	3,375	50	1.48%

VI. RISK ASSESSMENT

A limited risk assessment of the Company was performed to evaluate its compliance with the Indiana fair claims practices statutes and other related Indiana insurance laws and regulations, including the Indiana Compensation Act for Patients (INCAP). In order to evaluate the Company's compliance, the following information was requested:

- Written claims handling policies and procedures
- Minutes from all Board of Directors' meetings held during the examination period
- All internal claims audit reports performed during the examination period
- All reinsurance claims reports performed during the examination period
- All internal audits of defense counsel firms performed during the examination period
- The Company's claims check handling procedures
- The Company's complaint log and complaint handling procedures

Individual face-to-face interviews were conducted with the three (3) Claims Directors, a Senior Claims Specialist, a Claims Specialist and the Claims Operations Supervisor to determine the presence of claims handling controls, including written policies and procedures, the implementation of controls, and adequate monitoring procedures to determine compliance with fair claims handling statutes.

The Company provided a written statement indicating the Company does not maintain a claims manual or have any written claims handling procedures. The Company did provide a copy of its *Blueprint For Processing A Medical Malpractice Claim, which is made available to the insured and* which includes the steps a claim goes through from the time of its receipt and on through the litigation process, as required. It also provided a copy of the Company's claims check handling procedures. The Company provided access to an online version of its manual for processing claims materials in its OASIS claims system. Each of these items was reviewed and referred to during the examination of claims and will be commented on, if necessary, in the related sections of the report. Written procedures for establishing and adjusting claims reserves was requested and the Company stated it does not maintain written procedures for reserving.

The minutes from the Board of Directors' meetings showed there were four (4) Directors in 2002 with the number changing to five (5) by the end of 2006. During the period under examination, the Board of Directors was made up of five (5) senior officers of the Company.

The ProAssurance office in Indianapolis underwent two internal audits during the period under examination. The first internal audit was performed on October 1, 2002 and the auditors made four (4) recommendations and comments.

Another internal audit was performed on July 6, 2006; however, no recommendations were made and no items were brought to the attention of management.

The Company stated no reinsurance claims audit reports were completed during the period under examination because reinsurance is not a factor in the low limits required for Indiana medical malpractice policies.

The Company performed six (6) internal audits of defense counsel firms from November 2002 through July 2004. The internal auditors used a scoring worksheet that included the following seven (7) categories: Reporting, Pre-Medical Review Panel Activities, Medical Panel Review, Mediation, Depositions, Trial, and Fees and Billing. The auditors had a pre-chosen list of from ten (10) to fourteen (14) claim files to review at each defense firm. Each auditor reviewed and scored all of the files and then the files were discussed and a common score determined. The lowest overall score among the firms was 68.5% and the highest overall score was 93.0%. The Company informed the Department these audits have resulted in the termination of some law firms.

No internal audits of defense firms were performed during the remainder of the review period. A memorandum concerning this was provided which stated that during 2005 and 2006, the Company acquired new insurance entities and resources were redirected to work with the new companies and new law firms associated with those companies. The Company stated it plans to reinstate regular internal audits of defense firms in 2008 after the most recently acquired company is fully integrated. During a discussion of this issue at the exit conference, the Company stated it would like to provide additional written comments concerning defense firm audits. A summary of the additional comments provided is as follows:

The Company stated it does perform periodic audits of its defense firms and the last audit occurred in 2005. (Examiners' Note: A copy of the 2005 defense firms audit was not provided to the examiners.) The Company also stated it was the responsibility of every professional staff member in the Claims Department to continually assess the performance of the Company's defense attorneys. As litigation managers, it is the responsibility of each Claims Specialist and Claims Director to insure defense attorneys adhere to the Company claims philosophy of vigorously defending and protecting the reputation of its insureds. If, in a Claims Specialist's judgment, an attorney fails to meet Company expectations for defending insureds, the Claims Specialist is charged with addressing the deficiency directly with the attorney and bringing the deficiency to the attention of a Claims Director. When warranted, a Claims Director will address the deficiency with the specific attorney or a senior partner in the law firm. In some cases, the only redress is to terminate the engagement with the specific attorney, or in exceptional cases, the entire law firm. Finally, from time to time throughout the year, the Claims Directors will meet, either telephonically or in person, with the senior members of its defense firms to discuss issues, concerns or deficiencies that might need to be addressed.

The following reflect statements made during the individual face-to-face interviews of the three (3) Claims Directors, a Senior Claims Specialist, a Claims Specialist and the Claims Operations Supervisor:

- The Company has no written claims handling policies or procedures; however, the three (3) Claims Directors have direct interaction with their Claims Specialists on a daily basis and have direct knowledge of how many cases a Specialist has and the average life of each of the Specialist's claim files. Specialists are free to collaborate on their claims with other Specialists and with any of the Claims Directors as these people may have handled similar cases in the past

- The Company's claim volume, during the period of review, was 800 to 900 new claims each year and the Company usually tried 35 to 45 cases per year
- The Company takes a case through the full legal process
- The Company does not use staff attorneys to handle medical malpractice claims and/or suits. The Company's Legal Department handles only corporate matters and declaratory judgments when the Company takes legal action against an insured
- Any member of the claims staff will seek expert opinions deemed necessary from outside medical professionals. These medical personnel can and do serve as expert witnesses when necessary
- The Senior Vice President, Chief Claims Officer and the Company's internal Claims Review Committee, located in Birmingham, Alabama have claims settlement authority.
- All claims are processed by ProAssurance and the Company does not use third-party vendors for claims processing
- All claims payment checks are issued from the home office in Birmingham, Alabama. The examiners performed a time study on checks issued for twenty (20) claims to determine the time period from check issuance to the time the check was cashed by a bank. This time study will be discussed in the related section of this report

One (1) compliance issue is addressed in the risk assessment portion of this report. This issue arose from Indiana insurance law requirements as well as the Indiana medical malpractice laws which fall under the jurisdiction of the Indiana Department of Insurance (IDOI). These laws deal with fair and equitable claims settlements practices and other claims handling practices.

STATUTE CONSIDERED:
IC 27-4-1-4.5 Enumeration of unfair claim settlement practices; defines, in part, the following to be an unfair claim settlement practice:

"(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies."

The issue identified in this phase of the examination is as follows:

The Company does not maintain a claims manual or written claims procedures

Recommendation Number 1:
The Company should adopt and implement procedures to ensure a current claims manual or current written claims procedures are maintained. The Company should provide the IDOI with a compliance plan demonstrating how it will institute procedures to ensure a claims manual or written claims procedures will be published and maintained in a current form.

A review of the Company' complaint register was performed and each of the four (4) claims complaints found on the register was examined. No compliance issues were noted.

VII. CLAIMS

Standard 1
The Company is following Indiana insurance laws with regard to required elements for processing claims.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards for documentation exist. Determine whether standards comply with State statutes, rules and regulations.
- Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.
- Determine if initial contact with claimants meets required contract standards.
- Determine if subsequent responses and claims handling delays comply with applicable statutes, rules and regulations for unfair claims practices and medical malpractice claims procedures.
- Determine compliance with requirement to file policy, reserve and claims settlement forms with the Indiana Department of Insurance per Bulletin 119 (as promulgated under IC 34-18-9).
- Determine adequacy of claims notes or diary which document claim progression, correspondence, medical review panel activity and findings related to claims justification, litigation, claims settlement activity, court of jurisdiction review, sign off, and final settlement and payment, including information relating to the "periodic payments agreement" as defined in IC 34-18-14-1.
- Determine the amount of time between the time settlement is accepted by the claimant and the issuance of the settlement check and/or periodic payment agreement is completed.
- Determine compliance with the Indiana Department of Insurance Bulletin 119 as promulgated under IC 34-18-3 and 9 as it relates to Certificate of Insurance filings, reserves and final settlement amounts.

During the review it was determined the Company did not have a written claims manual or written reserving procedures that could be reviewed and verified to Company claims documents and the Company's computer claims system.

No exceptions were noted under Standard 1. Comments concerning the establishment and reporting of reserves at or exceeding statutory reporting limits will be addressed under Standard 8.

Standard 2
Timely investigations are conducted.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards exist.
- Determine whether Company standards comply with State statutes, rules and regulations per IC 27-4-14.5 of the Indiana insurance laws and IC 34-18-1 through 34-18-18 concerning medical malpractice claims.
- Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.
- Determine if initial contact with claimants meets required procedures.
- Determine if subsequent responses and claims handling delays comply with applicable statutes, rules and regulations for unfair claims practices and medical malpractice claims procedures.

No exceptions were noted under Standard 2 as it appeared the Company conducted timely investigations of all claims reviewed.

Claim Standard 3
Claims files are adequately documented.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and the Indiana medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards exist.
- Determine if quality of the claims documentation meets State requirements.
- Determine if claims files documentation is sufficient to support or justify the ultimate claims determination.

STATUTE CONSIDERED:
IC 27-1-3.1-9 Warrant; access to information; refusal; penalties; subpoenas; oaths; order to appear; states in part:

"Section 9(b) Every company or person from whom information is sought, and the officers, directors, and agents of the company or person, must provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined"

A sample of fifty (50) closed without payment claims was selected for review. During the examination, the Company could not produce one (1) closed without payment claim file for review.

The following table illustrates the population of claims closed without payment, sample size, the number of exceptions and the percentage to sample:

Claims Closed Without Payment
January 1, 2002 through December 31, 2006

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,375	50	1	2%

Since this closed without payment claim file could not be made available for review, it could not be determined that this file was in compliance with the criteria under Standard 3. After the examiners left the jobsite, the Company attempted to recreate this file by gathering materials from various outside sources involved with the claim. Although the recreated file was not complete, no exceptions in the handling of this claim were noted from the materials provided.

Recommendation Number 2:

The Company should adopt and implement procedures to ensure that complete claims files and other related claims information is maintained for the purposes of regulatory review. The Company should provide the Indiana Department of Insurance with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

Claim Standard 4
The initial contact by the Company with the claimant is within a reasonable time frame.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards exist. Determine whether Company standards comply with State statutes, rules and regulations per IC 27-4-14.5 of the Indiana insurance laws and IC 34-18-1 through 34-18-18 concerning medical malpractice claims.
- Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.
- Determine if initial contact with claimants meets required contract standards.

There were no exceptions found under Standard 4 during the examination.

Claim Standard 5
The Company responds to claims correspondence in a timely manner.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards exist.
- Determine whether Company standards comply with State statutes, rules and regulations per IC 27-4-14.5 of the Indiana insurance laws and IC 34-18-1 through 34-18-18 concerning medical malpractice claims.
- Determine if correspondence related to claims is responded to within a reasonable time and in accordance with State requirements.
- Review and cross reference internal audit reports of defense counsel firms to determine if a business practice of delays exists when using law firms to handle claims.
- Review the file notes to determine if Company claims personnel are timely in responding to correspondence from claimants or other outside interested parties.

There were no exceptions found under Standard 5 during this examination.

Claim Standard 6
Claims handling practices do not compel claimants to institute litigation in cases of clear liability and coverage to recover amounts due under policies by offering substantially less than due under the policy.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review samples of closed claims files.
- Determine if litigated files indicate problematic claims handling practices.
- Review Company procedures, training manuals and bulletins to determine if Company standards exist.
- Determine whether Company standards comply with State statutes, rules and regulations per IC 27-4-14.5 of the Indiana insurance laws and IC 34-18-1 through 34-18-18 concerning medical malpractice claims.
- Review internal audit reports of defense counsel firms to determine if delays are routine when using any particular law firm to handle claims.
- Review the file notes to determine if Company claims personnel are timely in responding to correspondence from claimants or other outside interested parties.
- Determine if the quality of claims documentation meets State requirements.
- Determine if claims files documentation is sufficient to support or justify the ultimate claims determination.

No exceptions were noted under Standard 6 during the examination.

Claim Standard 7
Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following

Review Procedures and Criteria

- Review Company procedures, training manuals and bulletins to determine if Company standards exist.
- Determine whether Company standards comply with IC 27-4-14.5 of the Indiana insurance laws and IC 34-18-1 through 34-18-18 concerning medical malpractice.
- Review claims files to determine compliance with IC 27-4-1-4.5 (4) which prohibits refusing to pay claims without conducting a reasonable investigation based upon all available information.
- Review claims files to determine compliance with IC 27-4-1-4.5 (6) which prohibits not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.
- Review claims files to determine compliance with IC 27-4-1-4.5 (14) which prohibits failing to promptly provide a reasonable explanation of the basis of the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

No exceptions were noted under Standard 7 during the examination.

Claim Standard 8
Claims files are reserved in accordance with the Company's established procedures and the Company follows applicable laws and regulations as required under the Indiana medical malpractice statutes.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Review Company claims procedure manuals for established reserving practices.
- Determine if individual reserves are evaluated and posted as required under IC 34-18-9-3(b).
- Determine if periodic reserve adjustments are made.
- Determine if reserves are excessive/inadequate.
- Determine if reserves are reduced if a redundancy is apparent.
- Determine if reserves and settlement amounts can be verified.
- Review and verify Board of Directors' appointed actuary's Annual Certification as filed with the Indiana Department of Insurance and related Company reserving methods and their adequacy.

STATUTE CONSIDERED:
IC 34-18-9-3 Notice of reserve by medical liability insurer; report of final adjudications and settlements, states in part:

"Sec. 3. (a) A health care provider's insurer shall notify the commissioner of any malpractice case upon which the insurer has placed a reserve of at least one hundred twenty-five thousand dollars ($125,000) [$50,000 before July 1, 1999]. The insurer shall give notice to the commissioner under this subsection immediately after placing the reserve. The notice and all communications and correspondence relating to the notice are confidential and may not be made available to any person or any public or private agency.
(b) All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner by the plaintiff's attorney and by the health care provider or the health care provider's insurer or risk manager within sixty (60) days following final disposition of the claim. The report to the commissioner must state the following:
(1) The nature of the claim.
(2) The damages asserted and the alleged injury.
(3) The attorney's fees and expenses incurred in connection with the claim or defense.
(4) The amount of the settlement or judgment."

In addition, Bulletin 119 (Effective July 29, 2003), Indiana Patient's Compensation Fund-Filings as promulgated under IC 34-18-3-2, states in part:

"This bulletin is directed to all insurers that provide coverage to health care providers under Indiana's Medical Malpractice Act. Bulletin 30 and Bulletin 68 are hereby withdrawn and replaced by this Bulletin 119...

IC 34-18-9-3 (a) states that the health care provider's insurer shall notify the Insurance Commissioner of any malpractice case upon which the insurer has placed a reserve of at least fifty thousand ($50,000) for occurrences of malpractice before July 1, 1999, or one hundred twenty-five thousand dollars ($125,000) for occurrences of malpractice on or after July 1, 1999. Attached to this Bulletin as Exhibit B is the form to be used for reporting this information to the Patient's Compensation Fund.

IC 34-18-9-3(b) requires the health care provider's insurer or risk manager to report to the department all claims settled or adjudicated to final judgment against the health care provider. The report shall be made within sixty (60) days after the final disposition and shall include the following:

(1) The nature of the claim;
(2) The damages asserted and the alleged injury;
(3) The attorney's fees ad expenses incurred in connection with the claim or defense; and,
(4) The amount of the settlement or judgment.

Attached to this Bulletin as Exhibit C is the form to be used for reporting this information to the Patient's Compensation Fund."

As noted in the Risk Analysis Phase and under Standard 1 of this examination report, the Company does not have written procedures for the establishment of claim reserves.

There were three (3) areas of concern noted when reviewing this Standard during the examination. The first area was two (2) closed without payment claims which had reserves that reached the statutory reporting limits; however, these reserve limits were not reported the Patient's Compensation Fund. Even though the final disposition of these claims was closure without payment, the Company should have reported these reserves to the Indiana Department of Insurance when the reserves reached or exceeded the statutory reporting limits required by IC 34-18-9-3(a).

The following table illustrates the population of claims closed without payment, sample size, the number of exceptions and the percentage to sample:

Claims Closed Without Payment
January 1, 2002 through December 31, 2006

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,375	50	2	4%

The second area of concern was reserve increases to or above statutory limits made to eight (8) paid claims without notification being sent to the IDOI as required by IC 34-18-9-3(a). During

the review, paid claims reserves were traced to the Company's "OASIS" claims system which showed the periodic changes to reserves as a claim progressed. In these instances, when the reserves changed to or above the statutory reporting level, the claims files were searched for copies of reporting notices to the IDOI. For these eight (8) files reviewed, no notices to the IDOI of the reserve changes were found.

The following table illustrates the population of paid claims, sample size, the number of exceptions and the percentage to sample:

Paid Claims
January 1, 2002 through December 31, 2006

Population	Sample Size	Number of Exceptions	Percentage to Sample
369	50	8	16%

The third area of concern was the establishment of a reserve when the Company was notified of a claim. The Company routinely set loss reserves at $10,000 to $12,500 and did not increase them until close to the settlement date. The review of paid claims showed sixteen (16) paid claims where the potential loss amount appeared to have reached or exceeded the statutory reporting level earlier, but the reserves were not properly increased until the claim was settled or a jury verdict was rendered. Loss reserves should be established or re-evaluated as soon as possible.

The following table illustrates the population of paid claims, sample size, the number of exceptions and the percentage to sample:

Paid Claims
January 1, 2002 through December 31, 2006

Population	Sample Size	Number of Exceptions	Percentage to Sample
369	50	16	32%

Recommendation Number 3:
The Company should adopt and implement procedures to ensure that reserves are established and re-evaluated, with procedures to ensure prompt and timely notification to the IDOI in accordance with Indiana law when the loss reserve on a medical malpractice claim reflects potential liability for the Indiana Patient's Compensation Fund.

Recommendation Number 4:
The Company should adopt and implement written procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company should provide the IDOI with a compliance plan demonstrating how the Company will verify that it properly reports reserves reaching at least $125,000.

Claim Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Determine if denied and closed-without-payment claims are based on policy provisions and applicable State statutes and regulations. (IC 34-4-1-4.5 and IC 34-18-1 through 34-18-18)
- Determine if notices of claims denials reference specific policy provisions or exclusions. Determine if the Company provides claimants with a reasonable basis for the denial as required by statute or regulation.
- Review and apply IC 27-4-1-4.5 (4), refusing to pay claims without conducting a reasonable investigation based upon all available information.
- Review and apply IC 27-4-1-4.5 (6), not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear. Review and apply IC 27-4-1-4.5 (14), failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer to a compromise settlement.
- Review and apply IC 27-4-1-4.5 (15), in negotiations concerning liability insurance claims, ascribing a percentage of fault to a person seeking to recover from an insured party, in spite of an obvious absence of fault on the part of that person.
- Where required, determine if claimants are provided instructions for having rebuttals to denials reviewed by the State Department of Insurance or by the Company.
- Determine outcome of Medical Review Panel and/or legal action by claimant.

No areas of concern were found under Standard 9 during this examination.

Claim Standard 10
Bank cancellation date on settlement checks reflect appropriate claim handling practices.

This standard was designed and implemented to determine if the Company is properly handling claims in accordance with the Indiana Unfair Claims Settlement Practices Act (IC 27-4-1-4.5) and Indiana's medical malpractice laws (IC 34-18-1 – 34-18-18). To determine compliance with Indiana laws, a review plan of procedures and criteria was developed from Indiana statutes and the NAIC Market Conduct Examiner Handbook which included the following:

Review Procedures and Criteria

- Perform a time study on canceled claims checks to ascertain whether claims checks are being promptly mailed or delivered.
- Determine if canceled checks include the correct payee and are for the correct amount.
- Ascertain whether checks purport to release the insurer from further liability when such is not the case.
- Review endorsements to see if they are consistent with payee name(s) listed on the check.

A sample of twenty nine (29) claims checks was selected and traced to the appropriate claim. The average number of days from the date a check was written to the date of bank cancellation was twenty-three (23) days. The shortest number of days taken to cash a check was six (6) days and longest number of days taken to cash a check was ninety-five (95) days. No exceptions were found.

VII. SUMMARY OF RECOMMENDATIONS

Recommendation #1 The Company should adopt and implement procedures to ensure a current claims manual or current written claims procedures are maintained. The Company should provide the IDOI with a compliance plan demonstrating how it will institute procedures to ensure a claims manual or written claims procedures will be published and maintained in a current form.

Recommendation #2 The Company should adopt and implement procedures to ensure that complete claims files and other related claims information is maintained for the purposes of regulatory review. The Company should provide the Indiana Department of Insurance with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

Recommendation #3 The Company should adopt and implement procedures to ensure that loss reserves are established and re-evaluated, with procedures to ensure prompt and timely notification to the IDOI in accordance with Indiana law when the loss reserve on a medical malpractice claim reflects potential liability for the Indiana Patient's Compensation Fund.

Recommendation #4 The Company should adopt and implement procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company should provide the IDOI with a compliance plan demonstrating how the Company will verify that it properly reports reserves reaching at least $125,000.

VERIFICATION UNDER OATH STATEMENT

We verify under oath that this document is the report of the examination, that we have reviewed this report in conjunction with pertinent examination workpapers, that this report meets the provisions for such reports prescribed by the Indiana Department of Insurance, and that this report is true and correct to the best of our knowledge and belief.

Kirk R. Yeager, Director
RSM McGladrey Inc.

SUBSCRIBED AND SWORN BEFORE ME THIS 29TH DAY OF OCTOBER, 2009, THAT KIRK R. YEAGER APPEARED PERSONALLY AND PRESENTED PROPER INDENTIFICATION

NOTARY

CHRIS A. HERNANDEZ
NOTARY PUBLIC
STATE OF COLORADO
My Commission Expires 11/03/2013

ProAssurance Companies
100 Brookwood Place
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December 15, 2009

Ms. Debra M. Webb
Attorney, Market Regulation
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

RE: The Medical Assurance Company, Inc.
Indiana Market Conduct Report
Company Response

Dear Ms. Webb:

We have reviewed the Market Conduct Examination Report on The Medical Assurance Company, Inc. ("TMAC") and offer the following responses to the recommendations contained therein.

Recommendation #1 The Company should adopt and implement procedures to ensure a current claims manual or current written claims procedures are maintained. The Company should provide the IDOI with a compliance plan demonstrating how it will institute procedures to ensure a claims manual or written claims procedures will be published and maintained in a current form.

Response to Recommendation #1 While the Company has always been committed to compliance and believes that it has always been in compliance with respect to the maintenance of written claims procedures, the Company has adopted and implemented procedures to ensure written claims procedures are maintained. The Company will provide, on a confidential basis, the IDOI with its compliance plan demonstrating how it will institute procedures to ensure written claims procedures have been published and maintained in current form.

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Recommendation #2 The Company should adopt and implement procedures to ensure that complete claims files and other related claims information is maintained for the purposes of regulatory review. The Company should provide the Indiana Department of Insurance with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

Response to Recommendation #2 While the Company has always been committed to compliance and believes that is has always maintained claim files on each claim, the Company has adopted and implemented procedures to ensure that complete claims files and other related claims information is maintained for the purpose of regulatory review. The one claim file that was unable to be produced was maintained at a third party storage vendor site. The use of this vendor is gradually being phased out due to the Company's own paperless document retention system. The Company will provide, on a confidential basis, the Indiana Department of Insurance with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

Recommendation #3 The Company should adopt and implement procedures to ensure that reserves are established and reevaluated, with procedures to ensure prompt and timely notification to the IDOI in accordance with Indiana Law when the loss reserve on a medical malpractice claim reflects potential liability for the Indiana Patient Compensation Fund.

Response to Recommendation #3 While the Company has always been committed to compliance and believes that it has always appropriately established and reevaluated reserves, the Company has adopted and implemented procedures to ensure that loss reserves are established and reevaluated, with procedures to ensure prompt and timely notification to the IDOI in accordance with Indiana law when the loss reserve on a medical malpractice claim reflects potential liability for the Indiana Patient Compensation Fund.

Recommendation #4 The Company should adopt and implement procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company will verify that it properly reports reserves reaching at least $125,000.

Response to
Recommendation #4 While the Company has always been committed to compliance and believes it has complied with the required notices, the Company has adopted and implemented procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company will, on a confidential basis, verify that it properly reports reserves reaching at least $125,000.

Thank you for the opportunity to respond to the concerns expressed in the report. If you need any further information or clarification, please feel free to contact me.

Sincerely,

Kathryn A. Neville

Kathryn A. Neville
VP, Compliance

THE MEDICAL ASSURANCE COMPANY, INC.
Now known as ProAssurance Indemnity Company, Inc.
PLAN OF COMPLIANCE
INDIANA MARKET CONDUCT EXAM
December 18, 2009

This Plan of Compliance is in response to the recommendations contained in the Market Conduct Exam performed by the Indiana Department of Insurance dated as of December 31, 2006, and submitted to the Department by the outside examiner on October 29, 2009. The following provides the recommendations and the Company's response to those recommendations. Under separate cover, the Company is providing verification of compliance with its plan including confidential and proprietary information revealing the specific actions taken as part of the Company's compliance for each recommendation.

Recommendation #1 The Company should adopt and implement procedures to ensure a current claims manual or current written claims procedures are maintained. The Company should provide the IDOI with a compliance plan demonstrating how it will institute procedures to ensure a claims manual or written claims procedures will be published and maintained in a current form.

Response to Recommendation #1 While the Company has always been committed to compliance and believes that it has always been in compliance with respect to the maintenance of written claims procedures, the Company has adopted and implemented procedures to ensure written claims procedures are maintained. The Company will provide, on a confidential basis, the IDOI confirmation of the steps that it has taken procedures it is instituting to ensure written claims procedures have been published and maintained in current form.

Recommendation #2 The Company should adopt and implement procedures to ensure that complete claims files and other related claims information is maintained for the purposes of regulatory review. The Company should provide the Indiana Department of Insurance with a compliance plan demonstrating how it will institute procedures to ensure proper internal controls are in place regarding record maintenance.

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Recommendation #4 The Company should adopt and implement procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company will verify that it properly reports reserves reaching at least $125,000.

Response to Recommendation #4 While the Company has always been committed to compliance and believes it has complied with the required notices, the Company has adopted and implemented procedures to ensure the Indiana Patient's Compensation Fund is notified immediately when the Company places a reserve of at least $125,000 ($50,000 on claims which occurred before July 1, 1999) on a medical malpractice claim. The Company will, on a confidential basis, provide the Department of Insurance with confirmation of the steps it has taken and procedures it is implementing to verify that it properly reports reserves reaching at least $125,000.